

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

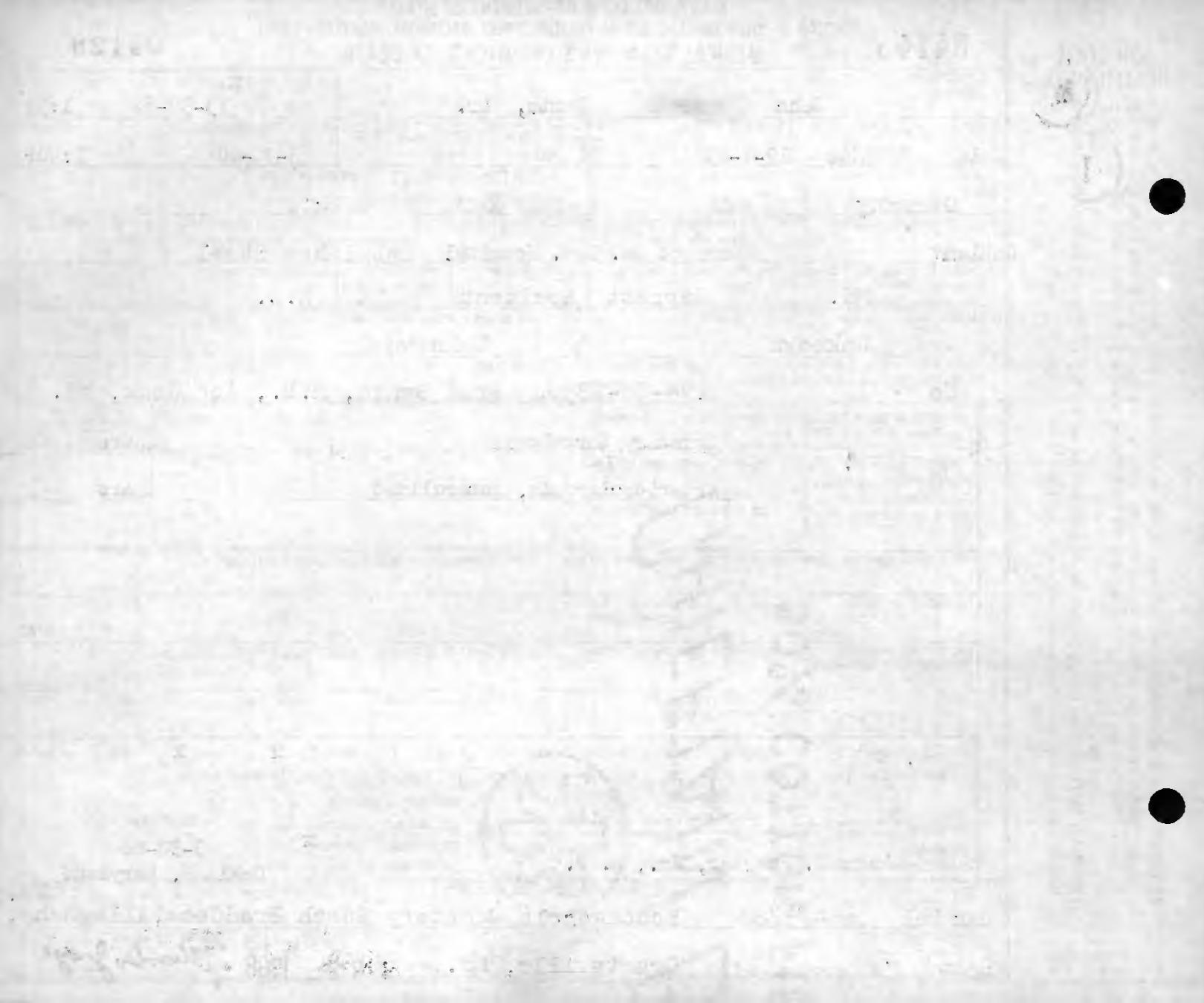
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---------|--|------------------------------------|---|---|--|--------------------------------|-----------------------------|--|
| I. DECEASED-NAME (Type or Print) | | First John | Middle Bentz, Sr. | Lost | 2d. DATE KNOWN OF ESTI. DEATH MADE | Month 3-30-68 | Day 19 | Year 1:32 M | 2b. HOURS |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS 84 YRS. | IF UNDER 24 HRS. DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month 3-30-68 | Day 19 | Year 1:40 P.M. | 2d. HOUR |
| Male | White | 12-7-83 | 84 | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH GARRETT | | | |
| Germany | | USA | | | | | | | |
| 10. CITY OR TOWN OF DEATH Oakland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bethlehem Steel | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Garrett | | 13c. CITY OR TOWN Accident | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER R.D. | | |
| 14. FATHER'S NAME Unknown | | 15. MOTHER'S MAIDEN NAME Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 174-05-8838A | | 17. INFORMANT Fred Bentz, R.D., Accident, Md. | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Coronary thrombosis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | Due to, or as a consequence of (b) Arteriosclerosis, generalized | | | | | | | Years |
| | | Due to, or as a consequence of (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| 19c. MEDICAL CERTIFICATION | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 3-30-68 | |
| EXAMINER'S (Name) James H. Feaster, Jr., M.D. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/3/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL Monongahela Cemetery | | 23d. LOCATION (City or Town) North Braddock, Alleghany, | | (County) (State) Pa. | |
| 24. FUNERAL DIRECTOR <i>Ruth Newman</i> | | ADDRESS Grantsville, Md. | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | DATE APR 2 1968 | |

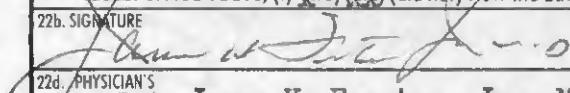
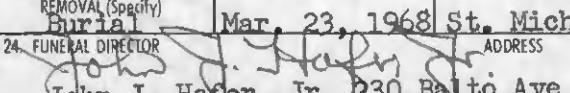
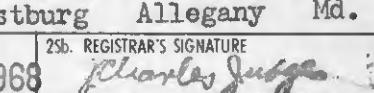


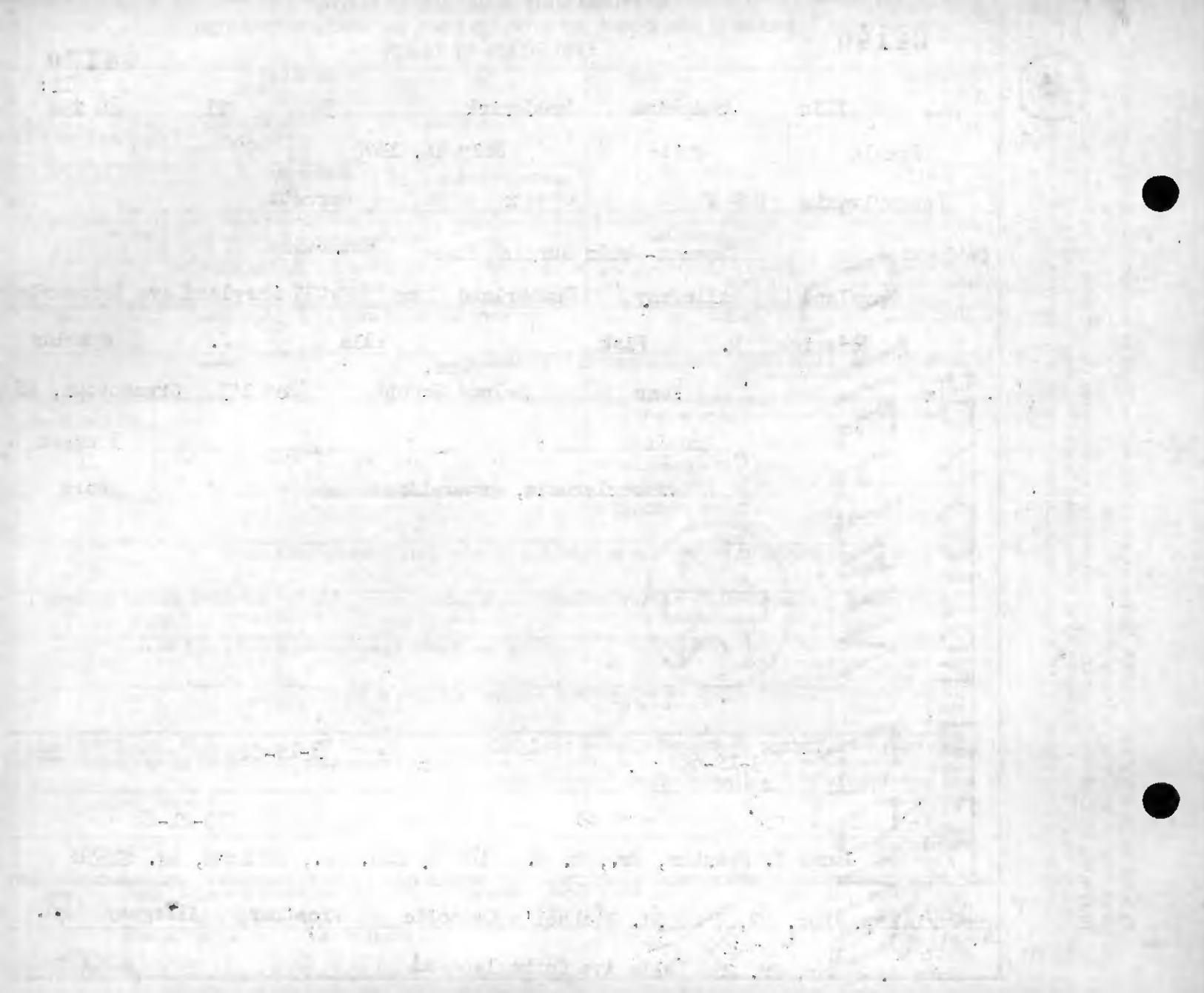
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|---|---|--|--|---|--|-------------------------|--|-----------------------|
| 1. DECEASED NAME (Type or print) | First Ella | Middle Josephine | Last Broderick | 2a. DATE OF DEATH Month 3 | Day 21 | Year 68 | 12b. HOUR 25A | | |
| 3. SEX Female | 4. RACE White | S. DATE OF BIRTH July 14, 1870 | 6. AGE (In years last birthday) 97 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. DAYS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH Garrett | | | | | | |
| 10. CITY OR TOWN OF DEATH Oakland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cuppatt-Weeks Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Allegany | 13c. CITY OR TOWN Cumberland | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER 737 Maryland Ave (Formerly) | | | | | |
| 14. FATHER'S NAME First Roderick | Middle D. | Last Fisk | 15. MOTHER'S MAIDEN NAME First Ella | Middle J. | Last Reynolds | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None | 17. INFORMANT Mrs. Halena Schott | Address Box 173 Cresaptown, Md | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF <u>440.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | years years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. _____ | City or Town _____ | County _____ | State _____ | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>1960</u> , 19____, to <u>3-19-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>3-19-68</u> , 19____, and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE  | | 22c. DEGREE <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. | 22d. ATTENDING PHYS. <input checked="" type="checkbox"/> | 22e. DATE SIGNED 3-21-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D. | | 22e. ADDRESS 104 S. 2nd. St., Oakland, Md. 21550 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Mar. 23, 1968 | 23c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Catholic | | 23d. LOCATION (City or Town) Frostburg | (County) Allegany | (State) Md. | | |
| 24. FUNERAL DIRECTOR  | | ADDRESS 230 Baltimore Ave Cumberland | 25a. REC'D BY REGISTRAR MAR 26 1968 | | 25b. REGISTRAR'S SIGNATURE  | | | | |



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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

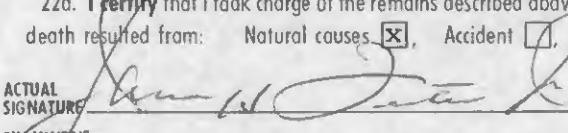
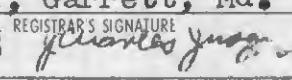
**FOR STATE
HEALTH DEPT**

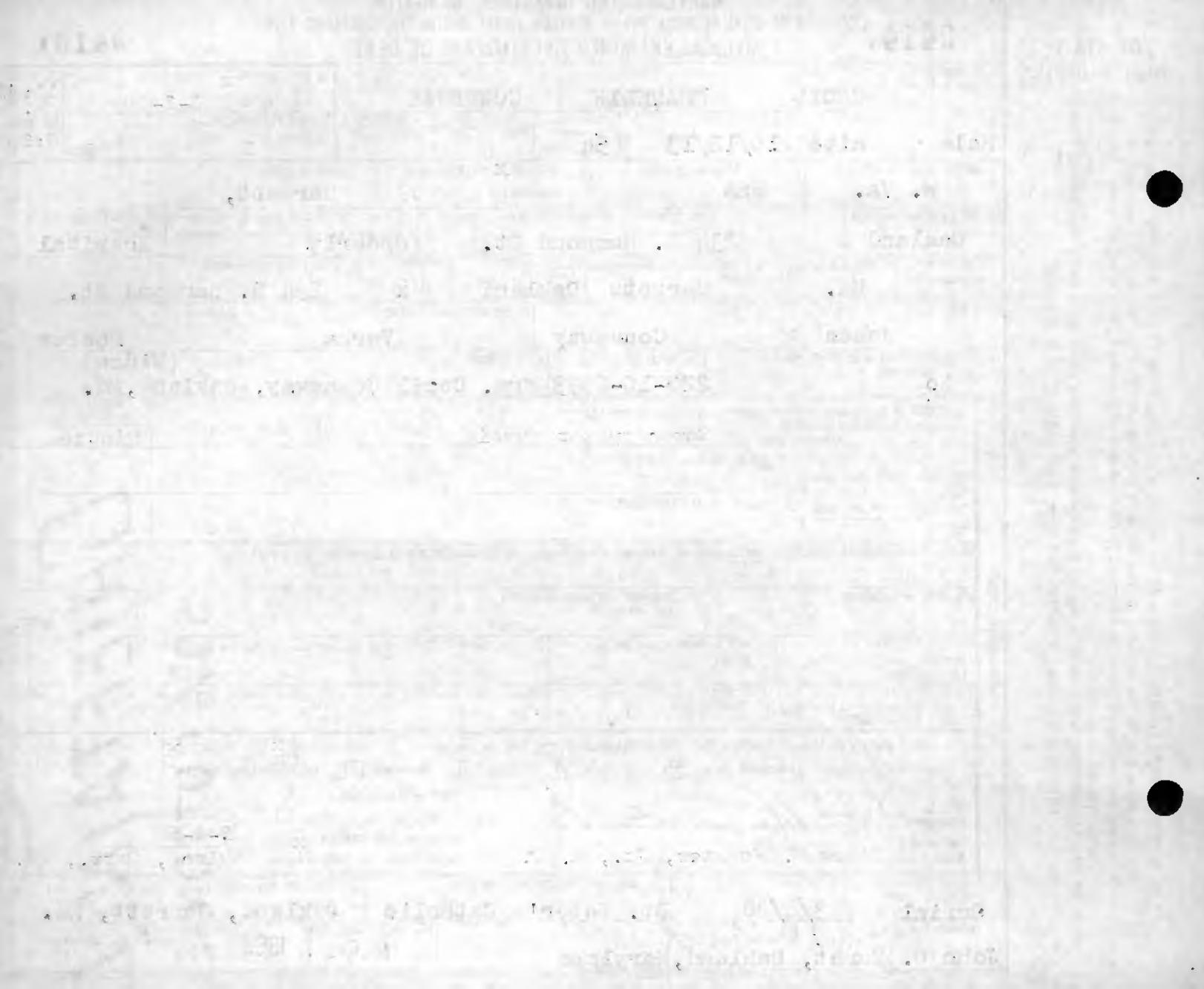
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Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|---|-------------------------|--|--|---|--|---|--|---|---------------------------------------|---|---|
| 1. DECEASED NAME (Type or Print) | | First CECIL | Middle FRANKLIN | Last CONNEWAY | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> | Month 3 | Day 3 | Year 1968 | 2b. HOUR 11:45 P.M. | | |
| 3. SEX Male | 4. RACE White | S. DATE OF BIRTH 10/12/13 | 6. AGE (in years less birthday) 54 YRS | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS. DAYS 0 | HOURS 0 | MIN. 0 | 2c. DATE PRONOUNCED DEAD Month 3 | Day 4 | Year 1968 | 2d. HOUR 8 A.M. |
| 7a. BIRTHPLACE (State or foreign country) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> | | NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Garrett, | | |
| 10. CITY OR TOWN OF DEATH Oakland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 234 N. Hammond St. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Orderly | | | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Garrett | | 13c. CITY OR TOWN Oakland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 234 N. Hammond St. | | | |
| 14. FATHER'S NAME First James | | Middle Conneway | Lost | 15. MOTHER'S MAIDEN NAME First Verna | | Middle | Lost | Rosier | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-10-2993 | | 17. INFORMANT Mrs. Cecil Conneway, Oakland, Md. | | | | | | ADDRESS (Widow) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF <i>4129</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2001</i> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| ACTUAL SIGNATURE  | | | | | | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D. | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/6/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Catholic | | 23d. LOCATION (City or Town) Oakland, Garrett, Md. | | (County) | (State) | | |
| 24. FUNERAL DIRECTOR John O. Durst | | ADDRESS John O. Durst, Oakland, Maryland | | 25a. REC'D BY REGISTRAR DATE MAR 7 1968 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

04148

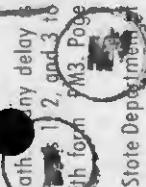
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---------|--|---|---|---|--|----------------------|
| 1. DECEASED NAME (Type or Print) | | | First | Middle | Lost | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year DEATH ESTI- MATED <input type="checkbox"/> 3-4-68 19 10:45 AM | 2b. HOUR 10:45 M |
| Audrey Ernest Cox | | | | | | | |
| 3. SEX | 4. RACE | S. DATE OF BIRTH | 6. AGE (In years less birthday) 72 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD Month 3 Day 4 Year 1968 | 2d. HOUR 10:45 AM |
| Male | White | 3-24-95 | | | | | |
| 7a. BIRTHPLACE (State or foreign country) W.Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Garrett | |
| 10. CITY OR TOWN OF DEATH Oakland | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W.Va. | | | 13b. COUNTY Ritchie | | 13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER RFD Pullman, W.Va. | |
| 14. FATHER'S NAME Moses H. Cox | | | 15. MOTHER'S MAIDEN NAME Margaret | | | 12b. KIND OF BUSINESS OR INDUSTRY Gen. Farming | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO. WW I 280-03-6576 | | | 17. INFORMANT Raiguel Funeral Home, Harrisville, WVa. | |
| ADDRESS | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4412 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| INTRA-ABDOMINAL HEMORRHAGE | | | | | | | |
| RUPTURED ARTERIOSCLEROTIC ABDOMINAL AORTIC ANEURYSM | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 451X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i> M.D. | | | | | | | |
| EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/6/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL Pullman Cemetery | | 23d. LOCATION (City or Town) (County) (State) Pullman, Ritchie, W.Va. | |
| 24. FUNERAL DIRECTOR <i>John O. Durst</i> John O. Durst, Oakland, Maryland | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAR 7 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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2000
2000
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FOR STATE
HEALTH DEPT.



Any delay
in filing
this form
will result
in a fine.
Any delay
in filing
this form
will result
in a fine.

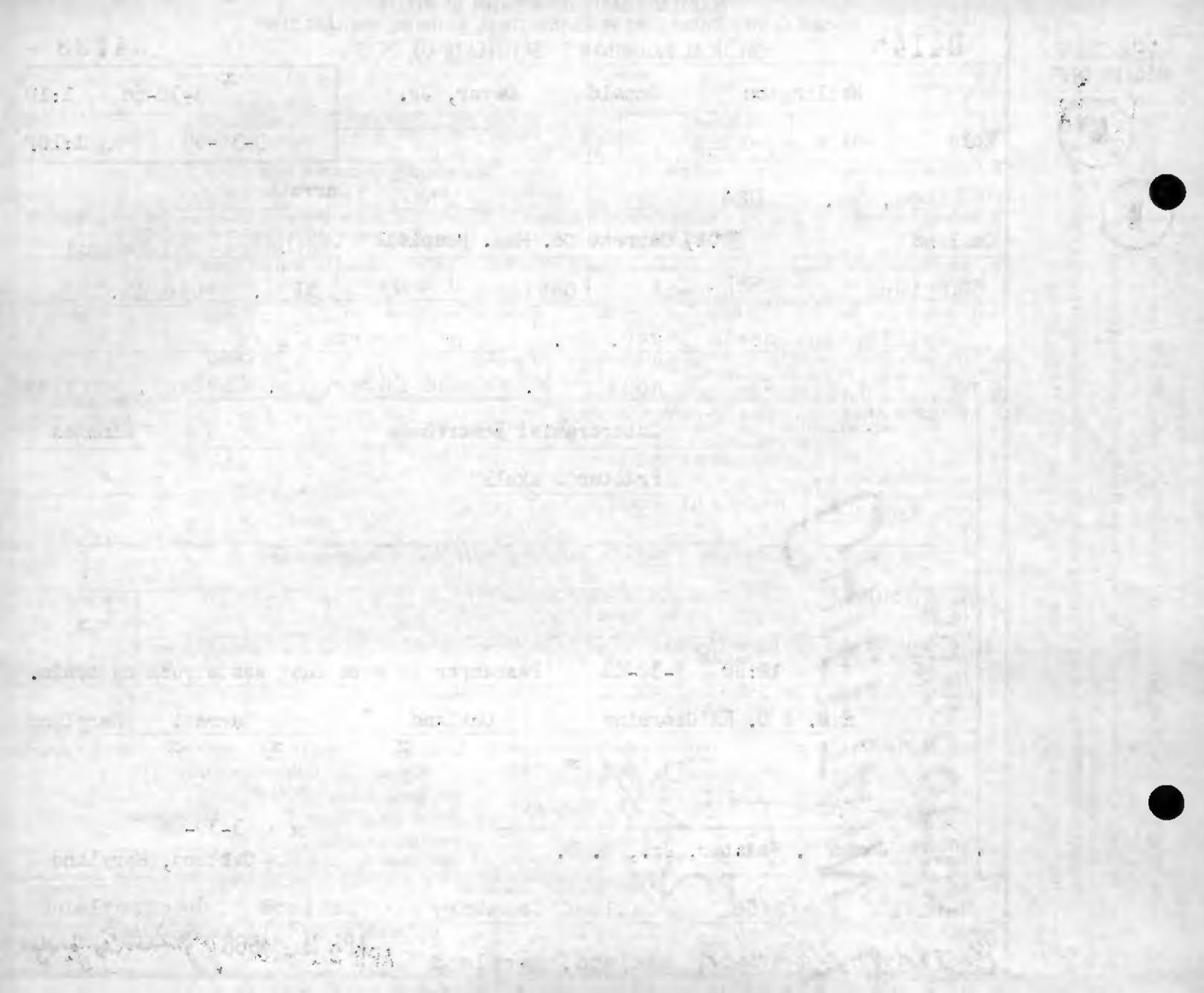
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|---|--|---|--|--------------------------------------|---|---|---|-------------------|------------------------------|--|
| 1. DECEASED NAME (Type or Print) | First Wellington | Middle Donald | Last Dever, Jr. | 2a. DATE KNOWN OF ESTI- DEATH MATED | Month 3-30-68 | Day 19 | Year 1968 | 2b. HOUR 1:10 P.M. | | | |
| 3. SEX Male | 4. RACE White | S. DATE OF BIRTH 2/25/58 | 6. AGE (in years last birthday) 10 yrs. | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS DAYS 0 | HOURS 0 | MIN. 0 | 2c. DATE PRONOUNCED DEAD Month 3-30-68 | Year 19 | 2d. HOUR 1:10 P.M. | |
| 7a. BIRTHPLACE (State or foreign country) Oakland, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Garrett | | | | | | |
| 10. CITY OR TOWN OF DEATH Oakland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital (DOA) Garrett Co. Mem. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student | | | 12b. KIND OF BUSINESS OR INDUSTRY School | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE Maryland | 13b. COUNTY Garrett | 13c. CITY OR TOWN Oakland | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER 31 E. Water St. | | | | | | | |
| 14. FATHER'S NAME Wellington Donald Dever, Sr. | First | Middle | Last | 15. MOTHER'S MAIDEN NAME Lena Roberta Glaze | First | Middle | Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none | 17. INFORMANT W. Donald Dever, Sr. | ADDRESS Oakland, Maryland | | | | | | | | |
| IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 810.1 DOUE TO, OR AS A CONSEQUENCE OF Fractured skull | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { b DUE TO, OR AS A CONSEQUENCE OF c | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8104 | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR XX 12:40 P.M. 3-30-68 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in auto that was struck by train. | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) B. & O. RR Crossing | 21f. LOCATION Street or R.F.D. No. Oakland | City or Town Garrett | County Maryland | State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4/2/68 | 23c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery | 23d. LOCATION (City or Town) Oakland | (County) Maryland | (State) | | | | | | |
| 24. FUNERAL DIRECTOR Gerald J. Minnick | ADDRESS Oakland, Maryland | 25a. REC'D BY REGISTRAR APR 2 - 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |
| VR A15ME (5) 10M REV. 1/68 | | | | | | | | | | | |



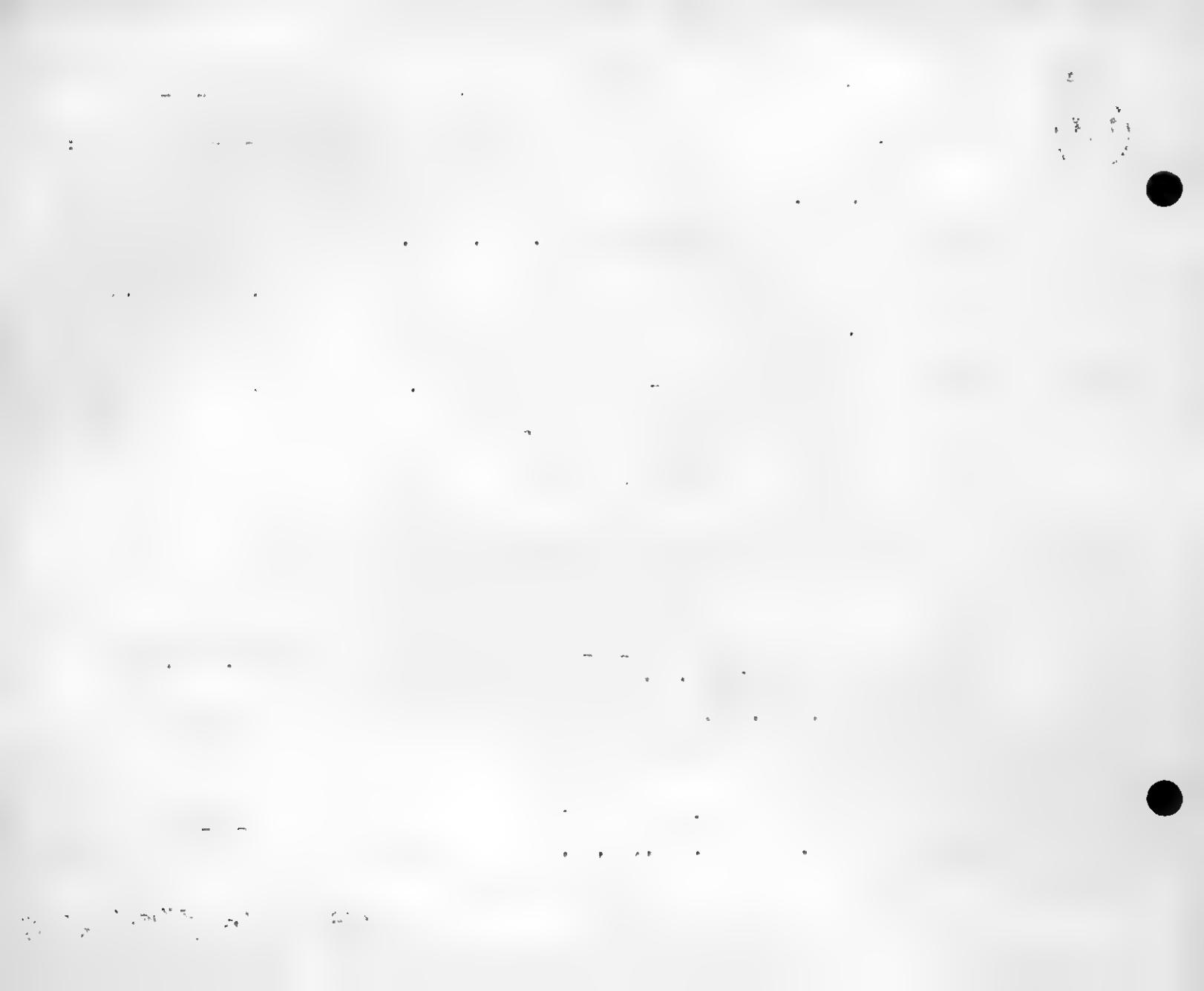
FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|-------------------------|--|---|--|--|--|---------------------------|------------------------------------|-----------------------|-----------------------|--|
| 1. DECEASED NAME (Type or Print) | | First Lena | Middle Pauline | Lost Glaze | 2a. DATE KNOWN DEATH ESTI. DEATH MATED | | Month 3-30-68 | Day 19 | Year 1968 | 2b. HOUR 1:10 P.M. | |
| 3. SEX Female | 4. RACE White | S. DATE OF BIRTH 2/3/1915 | 6. AGE (In years last birthday) 53 yrs | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 MRS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month 3-30-68 | | Year 19 | 2d. HOUR 1:10 P.M. | | |
| 7a. BIRTHPLACE (State or foreign country) Aurora, W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Garrett | | | | | | |
| 10. CITY OR TOWN OF DEATH Oakland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital (DON) Garrett Co. Mem. Hosp.) | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR IND. STRY Own Home | | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Garrett | | 13c. CITY OR TOWN Oakland | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER 22 E. Water St. | | | | | |
| 14. FATHER'S NAME First George | | Middle Wotring | Lost Ada | 15. MOTHER'S MAIDEN NAME First M | | Middle Teets | Lost | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-34-4517 | | 17. INFORMANT Robert L. Glaze, Sr. Oakland, Maryland | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 810.0 | | 19. DUE TO, OR AS A CONSEQUENCE OF Fractured skull | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes | | | | | |
| (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost) | | (b) | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 6/14 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month Day Year HOA 3-30-68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of auto struck by B. & O. Train | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) B. & O. RR. Crossing | | 21f. LOCATION Street or R.F.D. No Oakland | | City or Town Garrett | County Maryland | State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 3-30-68 | | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) Oakland, Maryland | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/2/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery | | 23d. LOCATION (City or Town) Oakland | | (County) Maryland | (State) | | |
| 24. FUNERAL DIRECTOR <i>Gerald N. Minnick</i> | | ADDRESS Oakland, Maryland | | 25a. REC'D BY REGISTRAR APR 2 - 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | |
| VR A15ME 10M REV 1/68 | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|------------------------|---|------------------------|---|--|--|---------------------|--|-------|
| 1. DECEASED NAME (Type or print) | | First ELSEY | Middle LLOYD | Last GLOVER | 2a. DATE OF DEATH Month MARCH | Day 31 | Year 1968 | 2b. HOUR 4:20PM | |
| 3. SEX MALE | 4 RACE WHITE | 5 DATE OF BIRTH MAY 30, 1888 | | 6 AGE (In years last birthday) 79 | | 7 IF UNDER 1 YEAR MONTHS 10 | | 8 IF UNDER 24 HRS DAYS 1 | |
| 7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 COUNTY OF DEATH GARRETT | | | |
| 10. CITY OR TOWN OF DEATH OAKLAND | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARRETT COUNTY MEMORIAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY FARMING | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13c. CITY OR TOWN GARRETT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER FRIENDSVILLE | | | |
| 14. FATHER'S NAME First LUCIUS | | Middle GLOVER | Last AMY | 15. MOTHER'S MAIDEN NAME First SCHMOPPS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO 176-16-1563 | | 17. INFORMANT (WIFE) LAURA E. GLOVER | | Address FRIENDSVILLE, MD. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 days | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerosis, generalized | | | | | | | | Years | |
| DUE TO, OR AS A CONSEQUENCE OF (b) lost. (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION 23 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that (1) (this hospital) attended the deceased from 3-2-68 19 1968 , to MARCH 31, 1968 , that (1) (we) last saw the deceased alive on 3-21-68 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>James H. Feaster, Jr., M.D.</i> | | 22c. DATE SIGNED 3-31-68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D. | | 22e. ADDRESS SECOND STREET OAKLAND, MD. 21550 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/3/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL Addison Cemetery | | 23d. LOCATION (City or Town) Addison, Penna. | | (County) (State) | |
| 24. FUNERAL DIRECTOR <i>James Joseph Williams</i> | | ADDRESS Kingwood, West Va. | | 25a. REC'D BY REGISTRAR 4 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | DATE 4/4/1968 | |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
152

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|---|--|--|---|--|-------------------|
| 1 DECEASED-NAME (Type or Print) | | First Louis | Middle Hacker | Last | 2a. DATE KNOWN <input checked="" type="checkbox"/> ESTI- DEATH MATED 3-24-68 19 | Month Day Year | 2b. HOUR 2 P M |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH 1-15-1888 | 6 AGE (in years at birthday) 80 YRS | IF UNDER 1 YEAR MONTHS DAYS | F UNDER 24 HRS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month 3-24-68 Year 19 | 2d. HOUR 3P M |
| 7a. BIRTHPLACE (State or foreign country) MD. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Garrett | | | | |
| 10. CITY OR TOWN OF DEATH Oakland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cuppett-Weeks Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 2b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY Allegany | | 13c. CITY OR TOWN Lonaconing | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER Lonaconing, Md. | |
| 14. FATHER'S NAME Henry | | Middle Hacker | Last Hacker | 15. MOTHER'S MAIDEN NAME Martha E. McKenzie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, or unknown) No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Martha Clark | | ADDRESS Lonaconing, Md. (Neice) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis +10.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 | | DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old cerebral vascular accident. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 3-24-68 3-24-68 Oakland, Md. 21550 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/27/1968 | | 23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Lonaconing, Md. | |
| 24. FUNERAL DIRECTOR George Eichhorn | | ADDRESS Lonaconing, Md. | | 25a. REC'D BY REGISTRAR DATE MAR 26 1968 | | 25b. REGISTRAR'S SIGNATURE George Eichhorn | |
| VR 415ME (5) 10M REV 1 68 | | | | | | | |



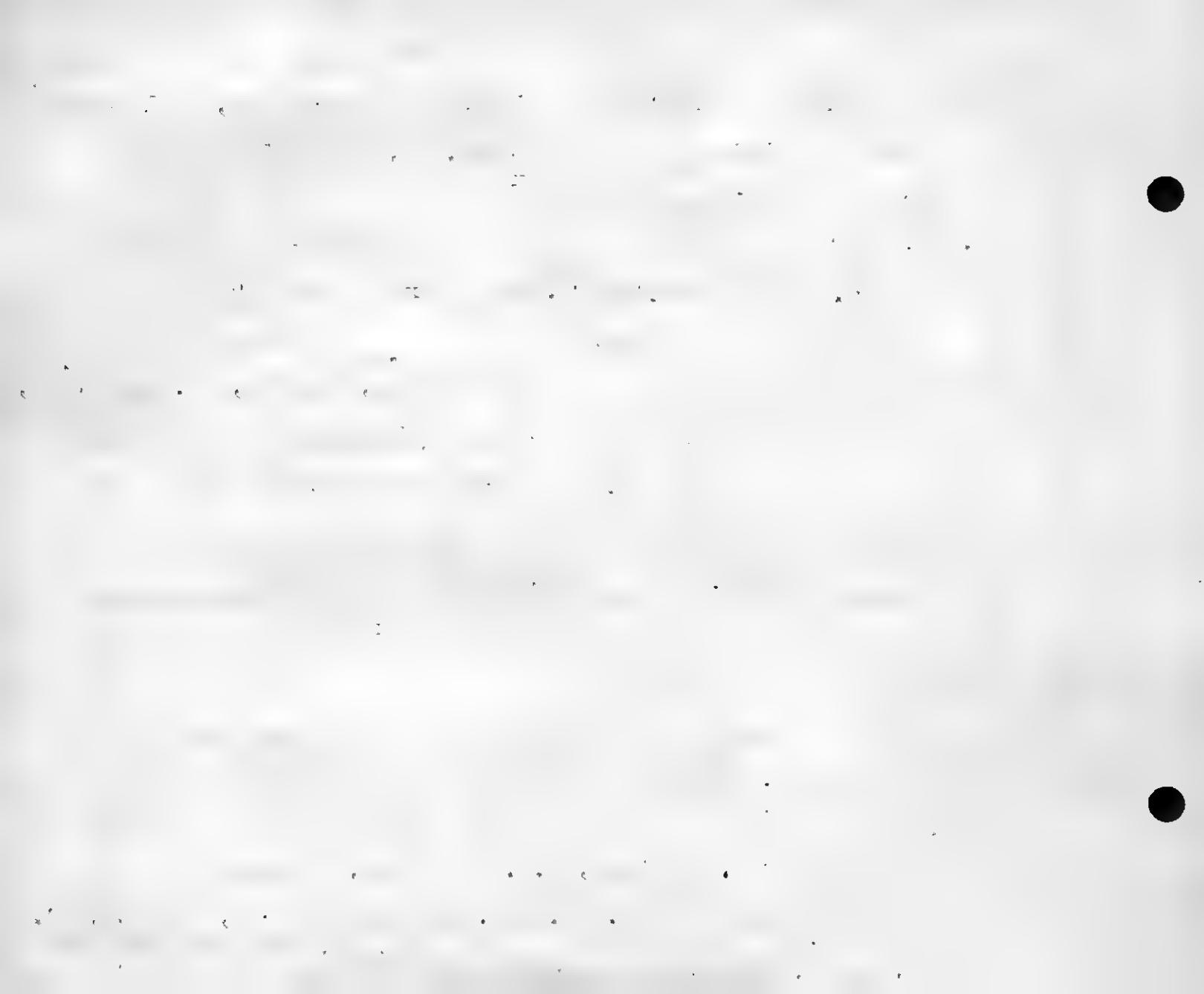
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|--|
| 1 DECEASED NAME (Type or print) | | | First SARAH | Middle AMELIA | Last HARVEY | 2o. DATE OF DEATH Month March | Day 26, | Year 1968 | Time Noon M | | | | |
| 3 SEX Female | | 4. RACE White | 5. DATE OF BIRTH Sept. 27, 1894 | | | 6 AGE (In years last birthday) 73 | | | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS DAYS 0 | IF UNDER 24 HRS HOURS 0 | IF UNDER 24 HRS MIN 0 | |
| 7o BIRTHPLACE (State or foreign country) Maryland | | 7b. CIT.ZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Garrett | | | | | | | |
| 10 CITY OR TOWN OF DEATH Mt. Lake Park | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12o USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Own home | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY Garrett | 13c. CITY OR TOWN Mt. Lake | | | 13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER Box 105 | | | | | | |
| 14. FATHER'S NAME First Charles | | Middle Buntz | 15. MOTHER'S MAIDEN NAME First Unknown | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Husband) James Harvey, Box 105, Mt. Lake Park, | | | Address Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension Anterior cerebral Division</i> Year DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus - Severe</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State | | | |
| 22o. I certify that (I) (this hospital) attended the deceased from <i>June 1958</i> , to <i>Mar 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>Mar 20 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Herbert H. Leighton</i> | | DEGREE MD | ATTENDING PHYS <input checked="" type="checkbox"/> | MED DIRECTOR <input type="checkbox"/> | STAFF PHYS <input type="checkbox"/> | 22c. DATE SIGNED 27 Mar 68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D. | | 22e ADDRESS Oakland, Maryland | | | | | | | | | | | |
| 23o. BURIAL, CREMATION, REMOVAL (Select) Burial | | 23b. DATE 3/29/68 | 23c. NAME OF CEMETERY OR CREMATORIAL Garr. Co. Mem. Gardens | | | 23d. LOCATION (City or Town) Oakland, Garrett, Md. | | (County) Garrett | | | (State) Md. | | |
| 24. FUNERAL DIRECTOR John O. Durst | | ADDRESS John O. Durst, Oakland, Maryland | | | | 25a. REC'D BY REGISTRAR Judge | | 25b. REGISTRAR'S SIGNATURE Judge | | | | | |
| | | | | | | DATE MAR 28 1968 | | | | | | | |



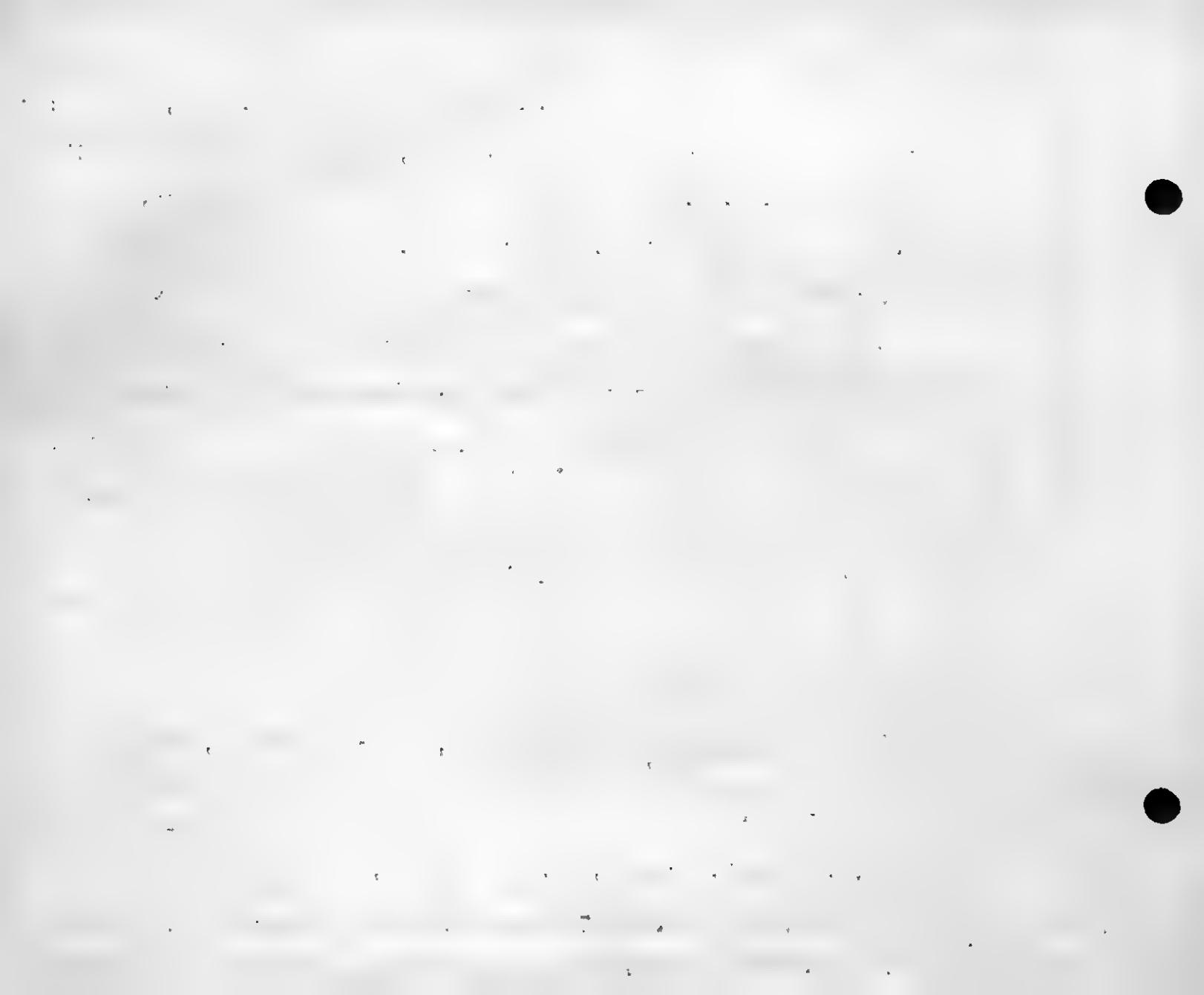
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|--|---|--|--|---|-----------------------------|---|---------------------------|
| 1 DECEASED NAME (Type or print) | | | First Baby | Middle Boy | Last Michaels | 2a. DATE OF DEATH Month March | Day 2 | Year 1968 | 2b. HOUR 2:00 M |
| 3. SEX Male | | 4 RACE White | 5. DATE OF BIRTH March 1, 1968 | | | 6. AGE (In years last birthday) YRS. 17 | | IF UNDER 1 YEAR MONTHS 4 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Garrett County, Md. | | | |
| 10 CITY OR TOWN OF DEATH Oakland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none | | | 12b. KIND OF BUSINESS OR INDUSTRY none | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Garrett | 13c. CITY OR TOWN Friendsville | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER General Delivery | | | | |
| 14. FATHER'S NAME First John | | | Middle Jesley | Last Michaels | 15. MOTHER'S MAIDEN NAME First Helen | | Middle Lucille | Last Sines | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b. SOCIAL SECURITY NO. --- | | 17. INFORMANT John W. Michaels | | | Address Friendsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Hours Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 7735 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) By dates, this infant is about 8 weeks premature | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1, 1968 , to March 2, 1968 , that (I) <input type="checkbox"/> lost saw the deceased alive on March 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Dr. James H. Feaster, Jr.</i> | | DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR | ATTENDING PHYS. <input checked="" type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 3-2-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. James H. Feaster, Jr. | | 22e. ADDRESS Oakland, Maryland 21550 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/3/68 | 23c. NAME OF CEMETERY OR CREMATORIAL Sand Springs Cemetery | | | 23d. LOCATION (City or Town) Garrett Co. | (County) Maryland | (State) | |
| 24. FUNERAL DIRECTOR <i>Gerald N. Minnick</i> | | ADDRESS Oakland, Maryland | | | 25a. REC'D BY REGISTRAR MAR 8 1968 | 25b. REGISTRAR'S SIGNATURE <i>Charles J. George</i> | | | |



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Garrett

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Mt. Lake Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Shady Acres

3. NAME OF
DECEASED
(Type or print)

First
Edna

Middle
Mae

Michaels

5. SEX

Female White

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

July 8, 1907

4. DATE
OF
DEATH

March 29, 1968

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Germania, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank William Cline

14. MOTHER'S MAIDEN NAME

Bertha Stella Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

212-24-2318 Arveta McCrum, Star Rt. Kitzmiller, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 18, 1965, to March 18, 1968, that (I) (we) last saw the deceased alive on March 18, 1968, and that death occurred at M. from the causes and on the date stated above.

22e. SIGNATURE

Dr. Andrew E. Mance

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
30 Mar 68

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

Oakland, Md. 21550

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Mar. 31/68

23c. NAME OF CEMETERY OR CREMATORIUM

Kalbaugh Cemetery

23d. LOCATION (City, town or county) (State)

Elk Garden, Mineral Co. W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE

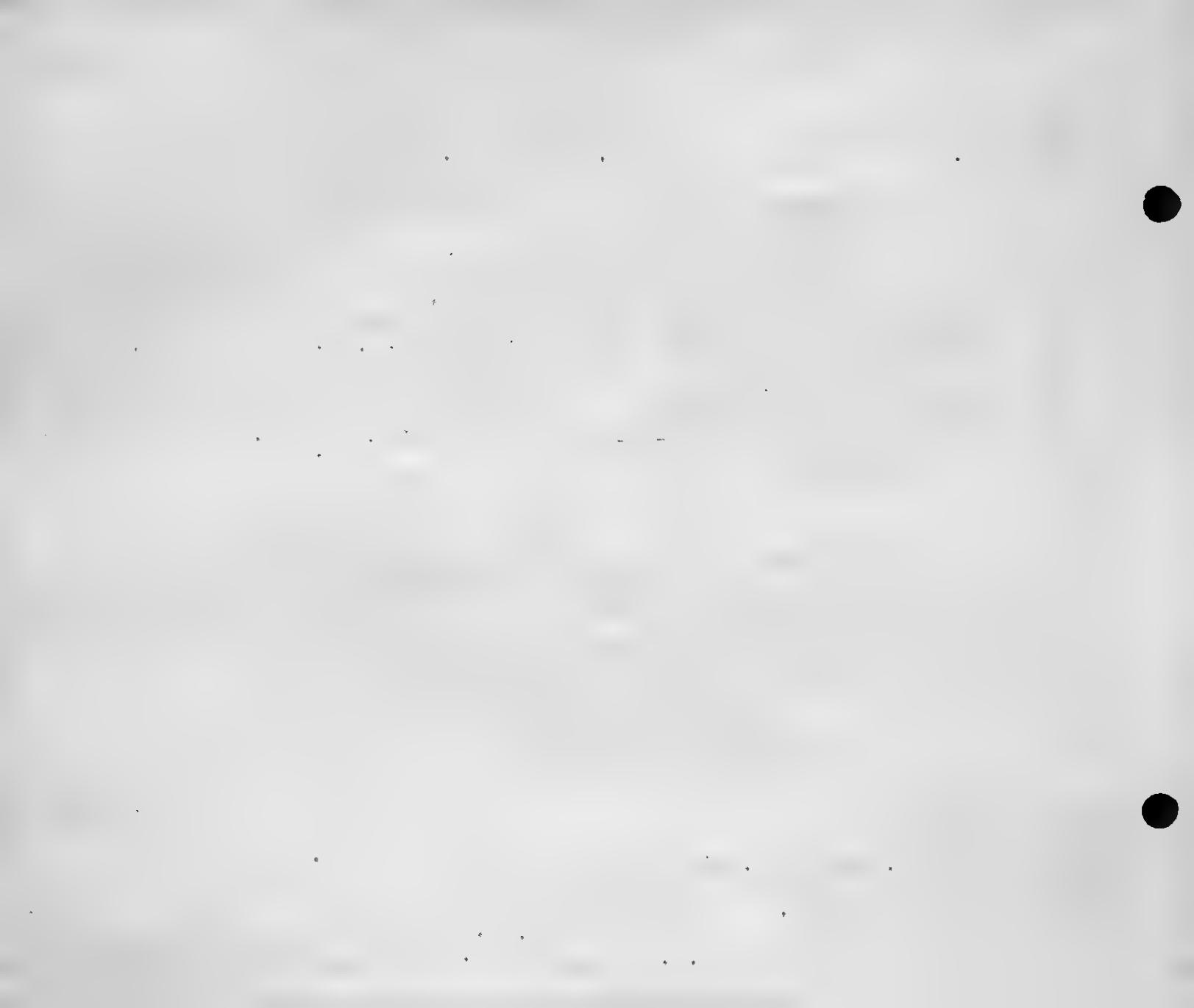
Arveta McCrum, Star Rt. Kitzmiller, Md.

24b. DATE 21558

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

APR 3 1968 Charles J. Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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| | | | | | | | | | |
|---|--|---|------------------|---|-------------------------------------|--|--------------|---|-----------------------------------|
| 1. DECEASED-NAME (Type or print) | | First John | Middle Thomas | Last Moore | 2a. DATE OF DEATH Month March | Day 9 | Year 1968 | 2b. HOUR a 4:30M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Oct. 8, 1900 | | 6. AGE (in years last birthday) 67 yrs. | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Loch Lynn, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH GARRETT | | | |
| 10. CITY OR TOWN OF DEATH Oakland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trackman | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland | | lived, if institution. Residence before 13b. COUNTY Garrett | | 13c. CITY OR TOWN Kitzmiller | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME John Bollen Moore | | | | 15. MOTHER'S MAIDEN NAME Daisy Mae Harvey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes | | 16b. SOCIAL SECURITY NO. WW 2 | | 17. INFORMANT Gertie V. Moore | | Address Kitzmiller, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: , IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Coronary Occlusion <i>udden</i> Lmonary artery disease <i>years</i> Hypertension <i>years</i> | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Tuberculosis | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> (cause of death (if either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1968, to Jan. 1968, that (I) (we) last saw the deceased alive on Jan. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE <i>A. E. Mance</i> | | DEGREE ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED March 11, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) A. E. Mance, M.D. | | 22e. ADDRESS Oakland, Md. 21550 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (specify) | | 23b. DATE 3/12/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gardens | | 23d. LOCATION (City or Town) Oakland, Maryland | | (County) (State) | |
| 24. FUNERAL DIRECTOR <i>Gerald D. Minnich</i> | | ADDRESS Oakland, Maryland | | 25a. REC'D BY REGISTRAR MAK 13 1968 | | 25b. REGISTRAR'S SIGNATURE <i>judge</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Garrett | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Swanton | | c. LENGTH OF STAY IN 1b 70 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R#1 - Swanton Rd. | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) FLORENCE JANE O'BRIEN | | 4. DATE OF DEATH Month MARCH Day 1 Year 1968 | |
| 5. SEX Female White | | 6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 15, 1890 | |
| 9. AGE (In years at death) 77 yrs. | | 10. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Garrett Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Augustus Bernard | | 14. MOTHER'S MAIDEN NAME Elizabeth Bernard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO | | 16. SOCIAL SECURITY NO. 212-24-1968 | |
| 17. INFORMANT Mrs. Glen O'Brien, Swanton, Md. | | Address R#1, | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 764 X DUE TO Acute Hypertensive Disease | | 2 days | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cardiac - Vascular Renal Disease | | 3 yrs | |
| (c) DUE TO Hypertension | | 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | |
| 442 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1957 to March 1968, that (I) (we) last saw the deceased alive on March 1 1968, and that death occurred at 2:16 P.M. for the causes and on the date stated above. | | 22b. DATE SIGNED March 2 1968 | |
| 22a. SIGNATURE Ralph Calandrella M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Ralph Calandrella, M.D. | | 22d. ADDRESS Kitzmiller, Md. 21538 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Mar. 4/68 | |
| 23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery | | 23d. LOCATION (City, town or county) Deer Park, Md. (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Amy Mildred Sharpless, Kitzmiller, Md. | | 25a. REC'D BY REGISTRAR Blaine, Va. | |
| | | 25b. REGISTRAR'S SIGNATURE Charles J. Jones | |
| | | DATE MAR 6 1968 | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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| | | | | | | | | | | | | |
|---|--|---|---|---|---|--|--|---|--|---|---------|--|
| 1. DECEASED NAME (Type or print) | | | First JOHN | Middle RILEY | Lost O'HAVER | 2a. DATE OF DEATH Month MARCH | Day 6, | Year 1968 | 2b. HOUR A 3:30M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH December 28, 1897 | | 6. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Garrett | | | | | | |
| 10. CITY OR TOWN OF DEATH Oakland | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Garr. Co. Mem. Hosp. Carpenter | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter | | | 12b. KIND OF BUSINESS OR INDUSTRY Building | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | | 13b. COUNTY Garrett | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Route #1 | | | | |
| 14. FATHER'S NAME First Joseph | | | Middle | Lost | 15. MOTHER'S MAIDEN NAME First Matilda | Middle | Lost | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 220-09-8260 | | | 17. INFORMANT Mrs. John O'Haver, Rt. 1, Oakland, Md. | | | Address (Widow) | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> Coronary Occlusion Leader DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease years DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis years | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | | | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 1967 to Oct. 1968, that (I) (we) last saw the deceased alive on Feb. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>A. E. Mance</u> | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS A. E. Mance, M.D. | | | 22c. DATE SIGNED 7 Mar 68 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/9/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL Taylor-Sines Cemetery | | | 23d. LOCATION (City or Town) Near Oakland, Garr., Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR John O. Durst | | ADDRESS | | | 25a. REC'D BY REGISTRAR MAR 11 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. Juge | | | | | |
| VR A154 30M REV. 1/68 | | | | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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| | | | | | | | | |
|---|--|---|---|--|---|--|-----------------------------------|------------------------------|
| 1. DECEASED-NAME (Type or print) | | First Myrtle | Middle Naomi | Last Robinette | 2a. DATE OF DEATH Month 3 | Day 26 | Year 68 | 2b. HOUR 3:15 P.M. |
| 3. SEX Female | | 4. RACE White | 5. DATE OF BIRTH Feb. 22, 1892 | | | 6. AGE (In years last birthday) 76 yrs. | | |
| 7a. BIRTHPLACE (State or foreign country) Garrett Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Garrett Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH Oakland, Md. | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W.Va. | | 13b. COUNTY C | 13c. CITY OR TOWN Moorefield | | 13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER Box # 422 | | |
| 14. FATHER'S NAME First John | | Middle T. | Last Grove | 15. MOTHER'S MAIDEN NAME First Mary | | Middle | Last Dawson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | | 16b. SOCIAL SECURITY NO 4129 | | 17. INFORMANT Mrs. Landon Vetter (Daughter) | | Address Oakland, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) arteriosclerotic Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF years Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) 4129 DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) 4129 | | | | | | | | |
| 19a. DATE OF OPERATION 4/22/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 17, 1968 , to March 26, 1968 , that (I) (we) last saw the deceased alive on March 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE A. E. Hance M.D. | | DEGREE M.D. | ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 26 March 68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. A. E. Hance (M.D.) | | 22e. ADDRESS Oakland, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (if any) 3-29-68 | | 23c. NAME OF CEMETERY OR CREMATORIUM Oliver's | | | 23d. LOCATION (City or Town) (County) (State) Moorefield Hardy Co. W. Va. | | | |
| 24. FUNERAL DIRECTOR Carl B. Thrush Moorefield, W. Va. | | ADDRESS | | 25a. REC'D BY REGISTRAR Charles J. George | | 25b. REGISTRAR'S SIGNATURE Charles J. George | | |
| | | | | DATE MAR 29 1968 | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 from this certificate and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|---|--|--|--|---|---|-------------------|-----------------|
| 1. DECEASED NAME (Type or print) Cecilia | | | First Middle Last Ross | 2a. DATE OF DEATH Month Day Year March 24 1968 | 2b. HOUR 7:30 AM | | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH April 9, 1892 | | | 6. AGE (in years last birthday) 75 YRS. | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS. DAYS 0 | HOURS 0 | MIN 0 |
| 7a. BIRTHPLACE (State or foreign (country) Selbysport, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH Garrett | | | | | | |
| 10. CITY OR TOWN OF DEATH Friendsville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) none | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE Maryland | 13b. COUNTY Garrett | 13c. CITY OR TOWN Friendsville | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER 0 | | | | | |
| 14. FATHER'S NAME First George | Middle Wolf | Last Frazee | 15. MOTHER'S MAIDEN NAME First Adeline | Middle Vanhorn | Last 0 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 215-12-2091 | 17. INFORMANT A. Donal Frazee | Address Selbysport, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic carcinoma | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Primary carcinoma of colon | | | | | | Months | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 15 S. X | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 15 S. X | | | | | | | | | |
| 19a. DATE OF OPERATION 1/5/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1963 , 19 68 , to 3-12-68 , 19 68 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 3-12-68 , 19 68 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Gerald N. Minnich | | 22c. DEGREE B.S. - | | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22d. DATE SIGNED 3-24-68 | | |
| 22e. PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D. | | 22f. ADDRESS 104 S. 2nd. St., Oakland, Md. 21550 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3/27/68 | 23c. NAME OF CEMETERY OR CREMATORIAL Grantsville Cemetery | | | 23d. LOCATION (City or Town) Grantsville | | (County) Maryland | (State) | |
| 24. FUNERAL DIRECTOR Gerald N. Minnich | ADDRESS Oakland, Maryland | | | 25a. REC'D BY REGISTRAR APR 1. 1968 | | 25b. REGISTRAR'S SIGNATURE Franklin J. Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G399 3/29/68 kk

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|---|---|---|---|--------------------------------------|
| 1. DECEASED NAME (Type or print) | First Edith | Middle May | Last Shaffer | 2a. DATE OF DEATH Month March | 2b. HOUR Day 19 Year 68 8:50AM |
| 3. SEX Female | 4. RACE White | S. DATE OF BIRTH May 10, 1894 | 6. AGE (In years 73 birthday 14 yrs.) | IE UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Horseshoe Run, W. Va. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Garrett Co., Md. | | |
| 10. CITY OR TOWN OF DEATH Oakland, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE W. Va. | 13b. COUNTY Preston | 13c. CITY OR TOWN Horseshoe Run | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER Horseshoe Run, W. Va. | |
| 14. FATHER'S NAME Edward | Middle Vinters | 15. MOTHER'S MAIDEN NAME First Matilda | Middle Last Roth | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None | 17. INFORMANT William Shaffer (Husband) | Address Horseshoe Run, W. Va. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 20 hours DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> — DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22o. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1968</u> , to <u>March 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Herbert J. Leighton</u> | DEGREE ATTENDING PHYS | <input checked="" type="checkbox"/> MED DIRECTOR | <input type="checkbox"/> STAFF PHYS | 22c. DATE SIGNED 19 Mar 68 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Herbert Leighton, MD | 22e. ADDRESS Oakland, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE March 22, 1968 | 23c. NAME OF CEMETERY OR CREMATORIUM Texas Cemetery | 23d. LOCATION (City or Town) Horse Shoe Run, W. Va. | (County) | (State) |
| 24. FUNERAL DIRECTOR | ADDRESS Davis, W. Va. | 25a. REC'D BY REGISTRAR DATE MAR 26 1968 | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |



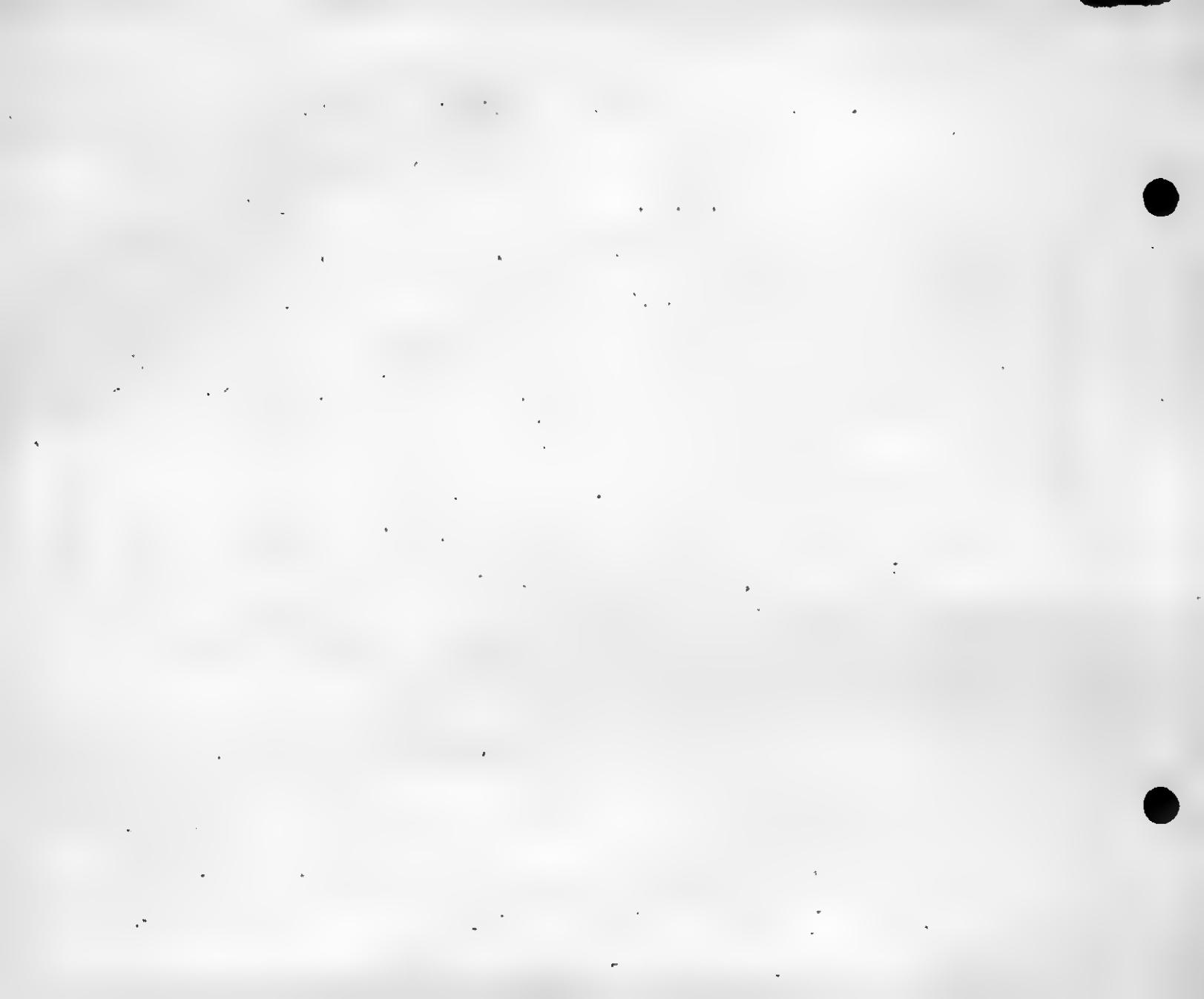
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) | | First <i>Angela</i> | Middle <i>Laura</i> | Lost <i>TICHINELL</i> | 2a. DATE OF DEATH Month <i>MARCH</i> | Day <i>3</i> | Year <i>1968</i> | 2b. HOUR <i>7:47 PM</i> | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MARCH 3, 1968 | | 6. AGE (In years last birthday) YRS 5 | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | 9. COUNTY OF DEATH GARRETT COUNTY | | | |
| 10. CITY OR TOWN OF DEATH OAKLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARRETT CO. MEMORIAL HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) — | | | 12b. KIND OF BUSINESS OR INDUSTRY — | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY GARRETT | | 13c. CITY OR TOWN SWANTON | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 13e. STREET AND NUMBER ROUTE #1 | |
| 14. FATHER'S NAME First <i>—</i> | | Middle <i>—</i> | Lost <i>—</i> | 15. MOTHER'S MAIDEN NAME First <i>MARGARET</i> | | Middle <i>—</i> | Last <i>LAURA</i> | 16. ADDRESS <i>HAGAR D. Tichinell Swanton, Md.</i> | |
| 17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hours | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Atelectasis - Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cerebral Anoxia</i> DUE TO, OR AS A CONSEQUENCE OF lost (c) <i>Partial Abruptio Placenta.</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Prematurity - 7 month gestation - (3 lb 11 oz Birth Wt.)</i> | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 3, 1968 , to MARCH 3, 1968 , that (I) (we) last saw the deceased alive on March 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Herbert H. Leighton</i> | | DEGREE <i>—</i> | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED <i>3 Mar 68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) DR. HERBERT LEIGHTON | | 22e. ADDRESS OAKLAND, MARYLAND 21550 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/4/68 | | 23c. NAME OF CEMETERY OR CREMATORIAL Turner Cem. | | 23d. LOCATION (City or Town) Swanton, Garrett Co., Md. | | (County) (State) | |
| 24. FUNERAL DIRECTOR: <i>J. Boal Westernport, Md.</i> | | ADDRESS | | 25a. DEATH REGISTRATION DATE MAR 5 1968 | | 25b. REGISTRAR'S SIGNATURE <i>—</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [initials] and [initials], and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers [initials] and 2 [initials] should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|---|---|--|--|--|--|---|-------------------------------|--|
| 1. DECEASED NAME (Type or print) | First David | Middle William | Last Walter | 2a. DATE OF DEATH Month 3 | Day 23 | Year 68 | 2b. HOUR AM 8:20 | |
| 3. SEX Male | 4. RACE White | S. DATE OF BIRTH July 29, 90 | 5. AGE (In years lost birthday) 77 | 6. IF UNDER 1 YEAR MONTHS YRS. | 7. IF UNDER 24 HRS DAYS HOURS | 8. IF UNDER 24 HRS MIN MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Oakland, Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH Garrett Co. | | | | | |
| 10. CITY OR TOWN OF DEATH Oakland, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Telegrapher | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Garrett | 13c. CITY OR TOWN Oakland, Md. | 13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 316 S. Sixth St. | | | | |
| 14. FATHER'S NAME First Lewis | Middle | Last Walter | 15. MOTHER'S MAIDEN NAME First Ella | Middle | Last Little | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | 16b. SOCIAL SECURITY NO. A-678509 | 17. INFORMANT Ellen Turney (Neice) | Address Oakland, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (d) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Stroke Inhalation (accidental) (b) DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease years Hyperensive Cardi-vascular Disease and Diabetes Mellitus | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 hrs | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hyperensive Cardi-vascular Disease and Diabetes Mellitus | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not while at work | 21b. TIME OF INJURY Hour AM Month Day Year 3:30 PM 3-22 1968 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Stroke Inhalation House fire | | | | | | |
| 21d. INJURY OCCURRED While at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.) Home | 21f. LOCATION Street or R.F.D. No. | City or Town Oakland Garrett Md | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on March 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE A. E. Mance | DEGREE MR | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR | STAFF PHYS <input type="checkbox"/> | 22c. DATE SIGNED 23 Mar 68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. A. E. Mance (Md) | 22e. ADDRESS Oakland, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3/26/68 | 23c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery | 23d. LOCATION (City or Town) (County) (State) Oakland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Gerald N. Minnich | ADDRESS Oakland, Maryland | 25a. REC'D BY REGISTRAR APR 1 - 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



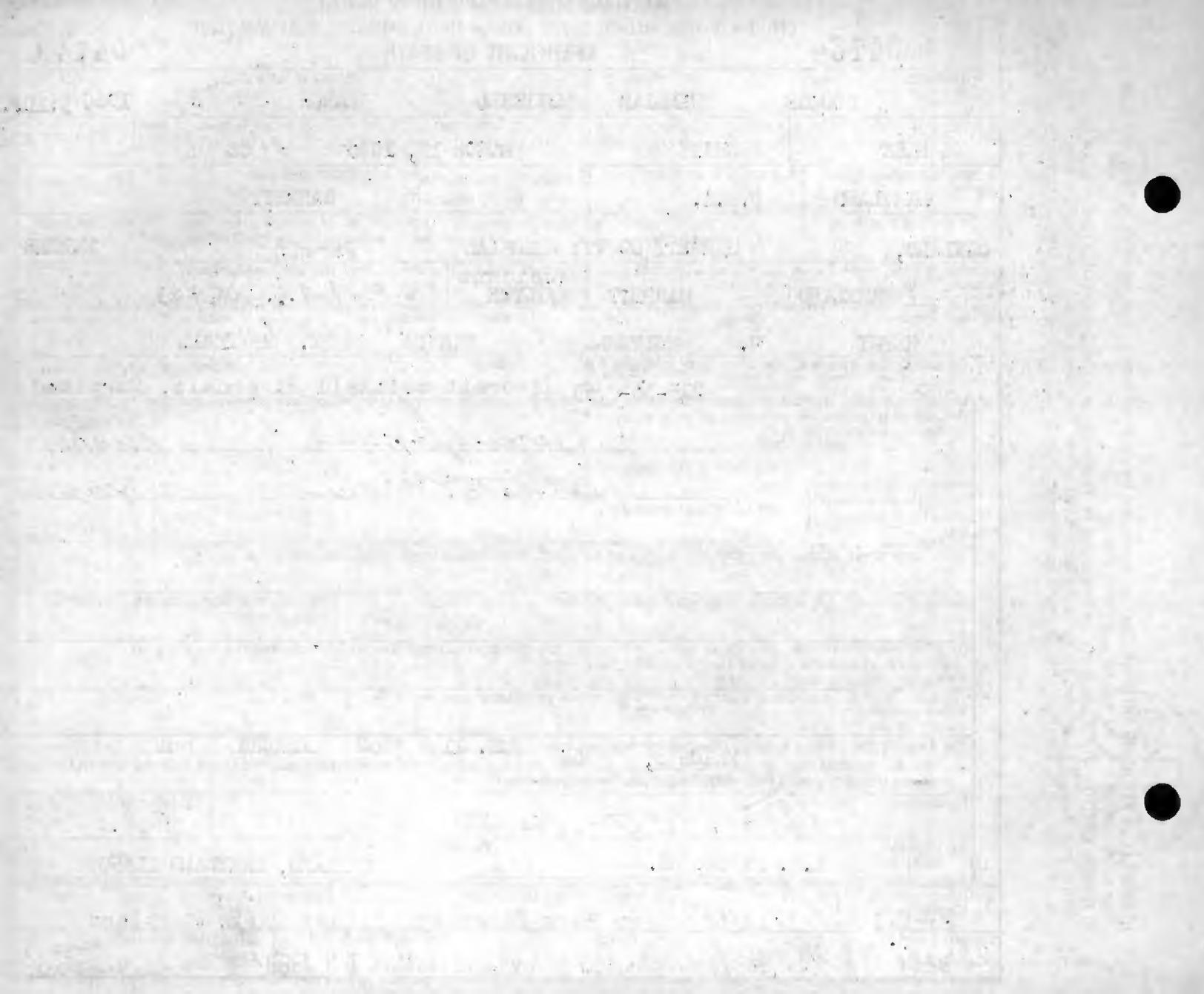
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|---|--|--|---|----------------------------------|
| 1. DECEASED-NAME (Type or print) | First GEORGE | Middle WILLIAM | Last WEITZELL | 2a. DATE OF DEATH Month MARCH | 2b. HOUR 8 Day 1968 | | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MARCH 18, 1886 | | 6. AGE (in years last birthday) 81 1/2 | IF UNDER 1 YEAR MONTHS 81 | IF UNDER 24 HRS. DAYS 0 | 2b. HOUR HOURS 5:10 |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH GARRETT | | | | |
| 10. CITY OR TOWN OF DEATH OAKLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARRETT COUNTY MEMORIAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming | | 12b. KIND OF BUSINESS OR INDUSTRY FARMER | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | 13b. COUNTY GARRETT | 13c. CITY OR TOWN ACCIDENT AVENUE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER P.O. BOX # 23 | | | |
| 14. FATHER'S NAME First HENRY | Middle W. | Last WEITZELL | 15. MOTHER'S MAIDEN NAME First FANNIE | Middle E. | Last WEITZELL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-36-9753 | 17. INFORMANT Everett Weitzell | Address Riverdale, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) DUE TO, OR AS A CONSEQUENCE OF 2029 Arteriosclerosis - | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months - years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2021 | | | | | | | |
| 19a. DATE OF OPERATION X MEDICAL CERTIFICATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB. 11, 1968 , to MARCH 8, 1968 , that (I) (we) last saw the deceased alive on MARCH 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | 22c. DATE SIGNED Mar 13 1968 | |
| 22b. SIGNATURE <i>A.E. Mance MD</i> | DEGREE <i>MD</i> | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | | | | |
| 22d. PHYSICIAN'S NAME (Type) A.E. MANCE, MD. | 22e. ADDRESS OAKLAND, MARYLAND 21550 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3/10/68 | 23c. NAME OF CEMETERY OR CREMATORIUM Deer Park Cemetery | 23d. LOCATION (City or Town) Deer Park, Maryland | (County) | (State) | | |
| 24. FUNERAL DIRECTOR <i>Gerald D. Minich</i> | ADDRESS <i>Oakland, Maryland</i> | 25a. REC'D BY REGISTRAR DAT | 25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i> | | | | |





04165

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

34250

| | | | | | | | | | | | | | |
|--|--|---|---------------|--|--|--|---|--|--|-----------------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | First Bura | Middle Margaret | Lost Wilson | 2a. DATE OF DEATH Month March Day 2, 1968 Year | 2b. HOME AM | | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH July 18, 1886 | | 6. AGE (In years last birthday) 81 | | IF UNDER 1 YEAR MONTHS YRS. | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | 9. COUNTY OF DEATH Garrett County, | | | | | | | |
| 10. CITY OR TOWN OF DEATH Oakland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Garrett | | 13c. CITY OR TOWN Swanton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Route # 1 | | | | | |
| 14. FATHER'S NAME William Curry | | Middle Tichnell | Last | 15. MOTHER'S MAIDEN NAME Ellen | | Middle | | Last Paugh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Riley Wilson | | Address Swanton, Md. | | | | | | | |
| IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF 4109 (b) <u>Arteriosclerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerosis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mns | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4201 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1967, to March 2, 1968, that (I) (we) last saw the deceased alive on March 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>B. L. Grant</u> | | DEGREE | | ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR | | <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED 3-3-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. B. L. Grant | | 22e. ADDRESS Oakland, Maryland 21550 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3/5/68 | | 23c. NAME OF CEMETERY OR CREMATORIUM Tichnell | | 23d. LOCATION (City or Town) Swanton | | (County) Garrett | | (State) Md. | | | |
| 24. FUNERAL DIRECTOR <u>S. Boral</u> | | ADDRESS Westernport, Md. | | 25a. REC'D BY REGISTRAR DATE MAR 7 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u> | | | | | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled ~~in~~ ^{by} the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

